

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

FILED JUN 15 1943

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 19324

Registration District No. 358

Primary Registration District No. 4523

Registrar's No. 11

1. PLACE OF DEATH:

(a) County Vernon  
(b) City or town Schell city  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution  
In this community about 57 yrs. (Specify whether years, months or days)

3. (a) PRINT FULL NAME MATTIE OWEN TEETOR

3. (b) If veteran, ✓ name war. 3. (c) Social Security No. ✓

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife J.H. Teetor 6. (c) Age of husband or wife if alive 79 years  
7. Birth date of deceased Sept. 20, 1863 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
79 8 10 hr. min.

9. Birthplace Ohio (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business  
12. Name Owen  
13. Birthplace Do not know (City, town, or county) (State or foreign country)  
14. Maiden name Do not know  
15. Birthplace " (City, town, or county) (State or foreign country)

16. (a) Informant J.H. Teetor  
(b) Address Schell city, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof June 1, 1943 (Month) (Day) (Year)

(c) Place: burial or cremation Green Lawn Cemetery

18. (a) Signature of funeral director Lute Lewis & Son  
(b) Address Schell city, Mo.

19. (a) May 31-43 (Date received local registrar) (b) Ante M. H. H. H. (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Vernon  
(c) City or town Schell city (If outside city or town limits, write "RURAL")  
(d) Street No. (If rural, give location)  
(e) Citizen of foreign country? (Yes or No) 8  
If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 30 year 1943 hour 9.30 minute 10 P. M.

21. I hereby certify that I attended the deceased from July 1, 1942, to May 1943, that I last saw her alive on May 29, 1943, and that death occurred on the date and hour stated above.

Immediate cause of death: Myocardiosis 5 yrs.  
Due to Hypertension 31 yrs.  
Due to arteriosclerosis 10 yrs.  
Other conditions Chronic nephritis 5 yrs.  
(Include pregnancy within 3 months of death)

Major findings: none performed  
Of operations none performed  
Of autopsy none performed

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify)  
(b) Date of occurrence  
(c) Where did injury occur? (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (b) Means of injury 2  
23. Signature M. G. Burke (M. D. or other) P. O.  
Address Rockville, Mo. Date signed 5/31/43

(Licensed Embalmer's Statement on Reverse Side)

1232

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Officer No. 7

District File Number

Date Filed

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.